M. J. Oldroyd, P. Papworth, Shirley A. Peacock, B. Philpott, B. A. Poley, C. J. F. Potter, S. Ramrakha, V. E. Rees, L. A. Reitsma, D. S. Robbie, J. R. Samuel, N. Sardana, A. Shamash, M. S. Sheshgiri, M. M. Som, W. McA. Speirs, B. R. Stead, J. H. Stevens, R. V. Steward, Margaret M. Sutherland, W. E. Sweetapple, W. S. Sykes, W. P. Thatte, M. A. Theeman, Helen L. Thompson, P. A. Tsoi-a-Sue, T. de L. Walker, J. R. W. Walsh, W. J. Walton, Audrey J. Wheeler, Valmae J. M. Wheeler, Doris S. Whiteford, Kathleen M. Whitfield, D. Williams, R. V. Young.

DIPLOMA IN MEDICAL RADIODIAGNOSIS.—K. R. Aberdour, J. E. B. Aling, A. Appleby, E. M. Bateson, Eleanour M. R. Besterman, G. P. Bradfield, Susan M. Broadbent, F. J. Brunton, E. H. Burrows, E. B. Davies, I. G. Emmanuel, F. Fletcher, L. V. Gould, N. Gupta, P. M. Hacking, A. Haylock, Mary A. Hewett, E. A. W. Houghton, V. H. Hutchinson, M. N. Jilla, L. Kreel, R. Leigh, L. R. Levin, J. J. McCavana, J. S. MacLean, D. J. Manton, M. Maskey, A. Meyer, T. J. O'Beirne, W. A. O'Brien, H. F. W. Pribram, S. S. Rao, C. J. Rhodes, R. E. Richardson, H. G. Row, J. Roylance, J. J. H. Rymer, S. S. Sandhoo, E. G. Shulman, F. Starer, H. B. Stentiford, F. C. Trembalowicz, J. P. Udawat, Brenda D. van Leuven.

DIPLOMA IN MEDICAL RADIOTHERAPY.—P. Banerjee, K. B. Chia, W. C. Constable, J. K. Donovan, Maureen B. Duthie, H. D. Friedberg, A. H. Laing, Maryam K. Mallick, A. H. W. Nias, R. Robillard, M. G. Sainz, A. Sarangi, A. D. Singh, Ngai-Chen Woo, Chun-Ming Yeung.

DIPLOMA IN PSYCHOLOGICAL MEDICINE.—J. P. Baker, G. J. Barry, I. Berman, Ann D. Black, S. Bourne, Joyce E. Brest, M. W. Browne, Elizabeth M. Bruce, M. W. P. Carney, M. D. Cashman, A. D. Charles, S. I. Cohen, Carice Ellison, M. D. Enoch, N. D. Farnan, A. R. Foster, H. C. Fowlie, H. L. Freeman, A. Galea, Mabel L. Haigh, J. V. Halpenny, M. A. Hargreaves, R. W. Johnston, W. Johnston, G. E. Langley, J. McDonald, J. Macintyre, Dorothy M. McWhirter, P. J. Mannion, D. H. Neale, J. W. G. Nixon, B. M. N. Pitt, G. Pollitt, V. R. Puzantian, W. H. Reid, R. Rodriguez-Arganaras, D. Rooney, L. F. W. Rowe, G. F. M. Russell, V. O. G. Smyth, D. I. Storey, P. Sykes, J. Warner, J. H. P. Willis, J. R. E. Wilson, Y. C. Wong.

DIPLOMA IN PATHOLOGY.—M. Y. Ali, B. C. Bhattacharyya, H. N. Harrison, T. Manners, T. K. Narayanan, Don S. P. S. V. J. Wijesekera.

DIPLOMA IN PUBLIC HEALTH.—S. L. Adesuyi, Lily Arratoon, L. H. Brearley, P. Changtrakul, E. Darabian, J. M. Deka, Lilian Kerr, Christine Kirby, W. G. Lewis, K. M. A. Malazie, Esther E. Simpson, M. F. X. Slattery, D. J. Stephen, G. C. Young.

DIPLOMA IN TROPICAL MEDICINE AND HYGIENE.—K. K. Appaji, G. Gajre, D. H. Melville-Swarries, Hnin Yee.

DIPLOMA IN CHILD HEALTH.—T. P. Linham, K. Tharmarajah.

ROYAL COLLEGE OF PHYSICIANS OF IRELAND

At a meeting of the College held on September 29, 1958, Major-General G. T. L. Archer was admitted to the Fellowship of the College.

On November 7, 1958, T. E. Lear, S. Lourdenadin, J. S. McCormick, and G. B. Plunkett were admitted to the Membership.

At a meeting of the College held on December 5, 1958, with the President, Dr. P. T. O'Farrell, in the chair, Dr. J. J. Cockburn was admitted to the Licence and Membership of the College.

The following were admitted to the Licence in Medicine and Midwifery:

Y. M. Ali, R. G. R. Bobart, R. J. Christmas, Margaret M. Day, K. A. Docrat, Noreen M. Duffy, Mearl A. Fenwick, M. N. Fitzgibbon, H. Holmes, S. N. Jeawon, O. C. Parry-Jones, H. A. Marcelin, Louisa E. Moran, M. A. Q. Muhairez, J. McAleer, J. F. McCusker, R. H. Narozny, J. C. Okoye, P. R. Panniker, Janina Pisko-Dubienski, D. L. Scawn, M. E. Seedat, Y. Z. Shah, A. L. Tawiah.

Vital Statistics

MEASLES

REPORTS FROM GENERAL PRACTITIONERS

We are much indebted to the general practitioners whose names appear below for the following notes on the present outbreak of measles.

Dr. G. F. WATSON (Peaslake, Surrey) writes: Measles was introduced just before Christmas by a child from Petworth. He went to school, coughing, on December 15–17, 1958, and to the school party that afternoon, after which he developed his rash. In school and at the party he was in contact with 52 children, 25 of whom were said to be susceptible. Of these, 21 (84%) developed measles, 2 on December 27, 2 on the 28th, 6 on the 29th, 9 on the 30th, 3 on the 31st, 3 on January 1, 1959, and 2 on the 2nd. The shortest incubation was thus 12 days and the longest 16 until the rash appeared. Out of 27 other children who were said to have had measles or were doubtful, 6 (22%) developed it. One child's mother said he was 3 months old when previously affected, which suggests confusion wtih roseola infantum.

Treatment of Attack.—No drugs are given for either the fever or the cough; if pressed, I dispense mist. salin. *B.N.F.* as a placebo. Glutethimide 125 mg. may be given in the afternoon if the child is restless when the rash develops; 250 mg. in single or divided doses at bedtime ensures a good night's sleep in spite of coughing. I encourage a warm humid atmosphere in the room by various methods: some electric fires and most electric toasters allow an open pan of water to rest on top; an electric kettle blows off too much steam to be kept on for more than short periods. Parents, conscious of the need to darken the room and to forbid reading, may carry this to an unnecessary extreme, starting even before the rash appears. To save a mother some demands, the wireless is a boon to children in darkened rooms. They are allowed up when the rash fades from the abdomen—usually the fourth or fifth day—and may go outside on the next fine day. Apart from fruit to eat, solid food is avoided on the day the rash is appearing; fruit drinks or soups are all they appear to want.

Complications.—So far few complications have arisen. Four cases of otitis media occurred in the first 25 children, but only one had pain. No case of pneumonia has occurred, but one child had grossly abnormal signs in the chest for a few days after the fever subsided, uninfluenced by oral penicillin. One girl had a tear-duct infection and another an undue blepharitis. Of three adult males with the disease, two have been more severely affected than any of the children.

Treatment of Complications.—For otitis media with or without pain oral penicillin in therapeutic doses is given four times a day. Dacryocystitis was treated with an oral mixture of penicillin and sulphonamide.

Interesting Features.—The invasion phase of measles this year seems to be more drawn out than previously. Several children have been febrile for a week, one for nine days before the rash appeared. In two boys measles was tentatively excluded: the first developed no catarrhal signs in spite of his fever, and then mumps appeared; the second, who was coughing, had an evening temperature of 102° F. (38.9° C.) for three nights running, before signs of primary atypical pneumonia appeared in the right lung. Two children have had transient rashes on the trunk before the typical rash appeared on the face. One girl, who was given gamma globulin as an infant when her elder brother had measles, was on this occasion a house contact of a younger brother with a typical attack; in due course she developed a low fever and transient catarrh but no rash, at the same time that her younger sister developed a typical attack of measles. In a neighbouring practice a baby of 9 months developed fever and catarrh, but no rash, at the same time as two older children in the house developed typical attacks of measles. A girl of 2 years who has not had measles in the past failed to develop it from house contact with her father, although her younger sister had a typical attack. A girl of 8 was not infected at the school party, though she nursed the ailing victim on her knee, but later took the disease from her sisters, who were infected at the party.

LATE START

Dr. F. H. STAINES (Callington, Cornwall) writes: This practice had a large epidemic of measles from July to October, 1957 (overlapping with the Asian influenza), and a small epidemic in April, 1958, occurring in a village that was bypassed by the 1957 infection. The current epidemic has not yet reached here, and in this practice only one of the last five epidemics has started early in the New Year, the others all starting in spring or summer.

BED REST

Dr. R. E. HOPE SIMPSON (Cirencester, Glos) writes: We make no attempt to prevent the spread of measles, and would only use gamma globulin to mitigate the severity of the disease in the case of the exposure of a susceptible adult or child who is already severely debilitated. Bed rest, for seven days for moderate and severe cases and of five to six days in mild cases, seems to cut down the incidence of such complications as secondary bacterial otitis media and bronchopneumonia. We have not been impressed by the prophylactic or therapeutic use of antibiotics and

sulphonamides in the first week of the disease. As soon as the patient is out of bed we allow him out of doors almost regardless of the weather.

Otitis Media and Bronchopneumonia.—These conditions often appear so early, sometimes even before the rash, that in such cases one can only conclude that the responsible agent is the virus itself. Despite their initial alarming severity, they tend to resolve spontaneously, and treatment apart from first principles seems useless. When, on the other hand, otitis media or bronchopneumonia comes on after the subsidence of the initial symptoms of measles, it is probably due to a secondary bacterial invader, and we find antibiotics or sulphonamides useful if the severity of the complication demands them.

Staphylococcal Infections.—Styes and blepharitis commonly develop within six weeks of measles and can be dramatically severe. They often persist as a recurrent nuisance for months or even years. In the long view local applications are conspicuously unsuccessful, as are courses of antibiotics. Prolonged use of sulphonamides, on the other hand, often seems to stop the cycle of recurrences, and heartening results are achieved by the old-fashioned iron tonics or their vitamin-and-iron successors.

Experience bears out the expectation that children under 2 years old usually have mild attacks, and under 6 months often escape the disease altogether. These mild attacks in infancy do not appear to give a solid immunity, and such children are often subject to a second attack when they reach school age. One wonders if the same principle applies to attacks modified by gamma globulin.

Less Severe.—The present outbreak in this area is not distinguished by any peculiar characteristics except that it seems less severe than usual.

MILD AILMENT

Dr. JOHN FRY (Beckenham, Kent) writes: The expected biennial epidemic of measles appeared in this region in early December, 1958, just in time to put many youngsters to bed over Christmas. To date there have been close on 150 cases in the practice, and the numbers are now steadily decreasing. Like previous epidemics, the primary cases have been chiefly in the 5- and 6-year-olds, with secondary cases in their younger siblings. No special features have been noted in this relatively mild epidemic. It has been mild because complications have occurred in only four children. One little girl aged 2 suffered from a lobular pneumonia, and three others developed acute otitis media following their measles. In the majority of children the whole episode has been well and truly over in a week, from the prodromal phase to the disappearance of the rash, and many mothers have remarked "how much good the attack has done their children," as they seem so much better after the measles.

A family doctor's approach to the management of measles is essentially a personal and individual matter, based on the personal experiences of the doctor and the individual character and background of the child and the family. In this practice measles is considered as a relatively mild and inevitable childhood ailment that is best encountered any time from 3 to 7 years of age. Over the past 10 years there have been few serious complications at any age, and all children have made complete recoveries. As a result of this reasoning no special attempts have been made at prevention even in young infants in whom the disease has not been found to be especially serious.

Treatment.—In the acute phase non-specific symptomatic measures such as aspirin and linctus have been the basis of treatment, and without the routine use of antibiotics or sulphonamides the rate of complications has not exceeded 3%. Even in the possibly susceptible "catarrhal children" with previous histories of recurrent ear and chest infections antibiotics have not been used in attempting to prevent complications; if and when these did occur they were treated on their merits. The few complications that did arise—namely, otitis media and chest infections—were either allowed to settle naturally on non-specific treatment, or, when severe enough, were treated with intramuscular injections of penicillin. In the present epidemic the one child with pneumonia and two of the children with acute otitis media were the only ones who required specific antibiotics. In all the others the disease followed a relatively uneventful course with complete and spontaneous resolution.

I would like to express my thanks to Dr. G. E. H. Callebaut, who has worked with me during this time.

NO PERMANENT DISABILITIES

Dr. R. M. MCGREGOR (Hawick, Roxburghshire) writes: In Scotland measles is not a notifiable disease except in the case of certain ports. Information concerning incidence, therefore, is known only to the family doctor and to a lesser extent the school authorities. In this area since 1948 serious outbreaks have occurred in the autumn of 1950, in March and April of 1953, and in June and July of 1955. In the intervening periods, and since the last serious outbreak, sporadic cases have occurred without causing an epidemic. At present we enjoy a complete freedom from this disease, and it is hoped that the act of writing on the subject will not incur the penalty of a visitation.

Scanning the notes of the previous epidemics, it is evident that the 1955 episode was one of low virulence. Indeed, many of the cases were sufficiently mild as to make diagnosis difficult. The follow-up of all the epidemics reveals that the patients have not suffered any permanent disabilities. This could be due to the treatment given being satisfactory or to the excellent recuperative powers of a sturdy population.

It is conspicuous that the 5–15-years age group contained the vast majority of the cases. No effort was made to prevent the spread of the disease, except the ordinary precaution of not permitting juvenile visitors. Gamma globulin to thwart the onset of the disease was never used, since the few cases seen affecting the adults have always been severe. It is felt advisable to get the infection over in childhood and thus avoid this hazard in later life.

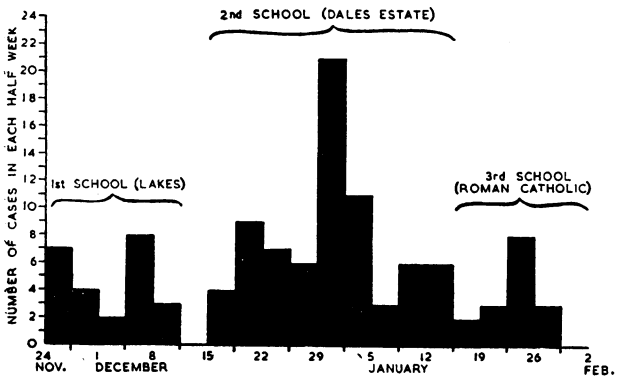
In these epidemics no serious complications were encountered. A troublesome cough for a few weeks after the infection was fairly frequent. In the 1955 episode only two cases of concomitant otitis media were seen, and in both cases it was a recrudescence of a previous attack. Contrariwise three of the cases had otitis media a few months before, and did not have a flare-up during the measles infection. In one case, as the rash of measles was fading, typical spots of chicken-pox were seen to develop. This superimposed infection did not prolong the convalescence.

The treatment given in all cases was sulphadimidine. In the older children it was dispensed in the form of tablets. In the younger children and in those that complained of difficulty in swallowing, the suspension was used. When the sulphadimidine was stopped, a sedative mixture was given to those who complained of a troublesome cough.

IMPORTANCE OF VISITS

Dr. KEITH HODGKIN (Redcar, Yorks) writes: If the present measles epidemic of nearly 100 cases is compared with the two previous epidemics (250 cases), no obvious differences are observed. Several clinical observations were made which influence early diagnosis and treatment: (1) In *all* cases the classic triad of cough, Koplik's spots, and rash was found. (2) The cough began 1–5 (usually 3) days before the rash in over 80% of cases. (3) Koplik's spots were never observed more than 2 days before the onset of rash. Extensive Koplik infiltration appearing as a diffuse red granularity over the inside of the cheeks indicated the likelihood of a severe illness. (4) A stage of pulmonary catarrh as judged by moist adventitious sounds was observed in 54% of cases. This stage always appeared 1–3 days after the appearance of rash—i.e., just as the clinical condition was improving. These catarrhal sounds had disappeared in most cases four days later.

Complications.—Only three complications were observed: (1) In 6% of cases the illness followed its normal course but was unusually severe. These cases developed severe prostration and rapid respiration while the rash was at its



height. Extensive Koplik infiltration usually proceeded these developments. (2) In 3% of cases the stage of pulmonary catarrh progressed to a pneumonitis, or bronchopneumonia, with persistent fever and localizing pulmonary adventitious sounds. (3) In 6% of cases there was acute otitis media which appeared to be related to the cough.

Prophylaxis.—Isolation is a practical impossibility. Gamma globulin was used successfully to protect weakly susceptibles on three occasions.

Treatment and Prevention of Complications.—Adequate bed rest, fluids, soluble aspirin, and a cough linctus were the routine treatment in all cases. Penicillin V was used in 12% of cases when there was clinical evidence of one of the three complications mentioned above. In a further 12% penicillin was used as an "umbrella" to protect chesty children.

In the three epidemics there were no deaths and no admissions to hospital, and in no case did pulmonary complications persist long enough to show on an *x*-ray when the child was well. Pneumonia is most likely to supervene during the stage of pulmonary catarrh when the child is improving clinically. At this stage parents, especially those in overcrowded homes, are apt to allow children to get up or even to go out. The most important measure is to insist on absolute bed rest until fever and chest signs have disappeared. *Visiting on alternate days to ensure that parents carry this out is essential.*

It is suggested that the many good results claimed for different forms of therapy in measles may be artificial, and that it is the frequent visiting by the interested clinician and not the therapy which produces the good results.

Week Ending January 24

Infectious diseases were more prevalent in England and Wales during the week ending January 24. The rises in the numbers of notifications included 1,038 for measles, from 12,671 to 13,709, 355 for dysentery, from 839 to 1,194, 325 for scarlet fever, from 1,103 to 1,428, 150 for whooping-cough, from 508 to 658, 93 for food-poisoning, from 107 to 200, and 84 for acute pneumonia, from 527 to 611.

The largest rises in the incidence of measles were 201 in Middlesex, from 640 to 841 (Harrow M.B. 102, Ealing M.B. 88, Wembley M.B. 80), 153 in Bedfordshire, from 272 to 425 (Luton M.B. 180), 152 in Hampshire, from 178 to 330, 122 in Yorkshire West Riding, from 1,223 to 1,345 (Sheffield C.B. 214, Leeds C.B. 197, York C.B. 106), 116 in Essex, from 1,047 to 1,163 (Ilford M.B. 195, West Ham C.B. 148), and 104 in Warwickshire, from 402 to 506 (Birmingham C.B. 188, Coventry C.B. 140); the largest exceptions to an increased incidence were falls of 133 in Lincolnshire, from 452 to 319, and 77 in Staffordshire, from 441 to 364. No large fluctuations were recorded in the local returns of whooping-cough. The largest increases in the number of notifications of scarlet fever were 45 in Yorkshire West Riding, from 137 to 182, and 36 in Hertfordshire, from 47 to 83. 4 cases of diphtheria were notified, being 1 more than in the preceding week.

The notifications of acute poliomyelitis numbered 18 and were 7 fewer for paralytic and 1 fewer for non-paralytic cases than in the preceding week. The largest returns were 3 cases in Essex and in Cheshire.

Another 40 cases were notified from the outbreak of *Salmonella limete* paratyphoid fever in Nottingham C.B., where 28 cases were notified in the preceding week.

The largest rise in dysentery was 72 cases in Glamorganshire. The chief centres of infection were Glamorganshire 201 (Cardiff C.B. 84, Barry M.B. 62, Rhondda M.B. 37), Yorkshire West Riding 175 (Leeds C.B. 107, Bradford C.B. 24), Lancashire 109 (Liverpool C.B. 36, Eccles M.B. 16, Manchester C.B. 12), Lincolnshire 87 (Grimsby C.B. 38, Boston M.B. 15, Scunthorpe M.B. 10), London 79 (Wandsworth 18, Bermondsey 15), Essex 76 (Walthamstow M.B. 48), Warwickshire 66 (Coventry C.B. 55, Birmingham C.B. 10), Nottinghamshire 60 (Carlton U.D. 46), Yorkshire East Riding 43 (Kingston upon Hull C.B. 30), Hampshire 35 (Southampton C.B. 21), Staffordshire 35 (Litchfield R.D. 11, Stoke on Trent C.B. 10), Durham 25 (South Shields C.B. 12), Middlesex 24, and Northumberland 21 (Newcastle upon Tyne C.B. 21).

Venereal Diseases

In England and Wales during the quarter ending September 30, 1958, 1,032 new cases of syphilis were reported as attending the clinics, as compared with 1,240 the previous year. Of these, 170 were classified as primary, secondary, or latent in the first year of infection. 7 cases of congenital syphilis in children aged under 1 year were reported, and 96 cases in persons over that age. New cases of gonorrhoea (with corresponding 1957 figures in parentheses) numbered 7,986 (7,155), of chancroid 65 (66), and of non-gonococcal urethritis (males only) 5,197 (4,408).—*Monthly Bulletin of the Ministry of Health,* January, 1959.

Influenza

In the week ending January 24, 55 deaths from influenza were reported in England and Wales. This total was 22 more than in the previous week, but it is only a quarter of the total in the corresponding week last year, when Asian influenza was epidemic. Pneumonia notifications remain low for the time of year (see graph). In the week ending January 24 there were 875 deaths from pneumonia, compared with 992 in the corresponding week last year. Influenza-like illness has been reported in a few scattered districts, and serological evidence of the Asian strain has been obtained in some cases. In Birmingham for about three weeks there has been a sustained demand for hospital beds for infants with acute respiratory disease.

Industrial Accidents and Diseases

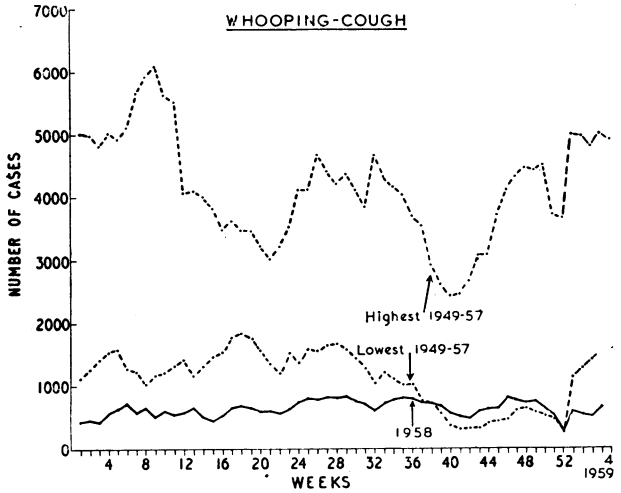
A total of 1,183 workpeople died from notifiable accidents in the course of their employment in Great Britain during 1958, compared with 1,272 in 1957. The number of cases of industrial diseases reported was 469, of which 17 were fatal; the numbers for 1957 were 518 and 15. The 1958 deaths were as follows: epitheliomatous ulceration due to mineral oil 11 and due to pitch and tar 5; toxic jaundice 1.

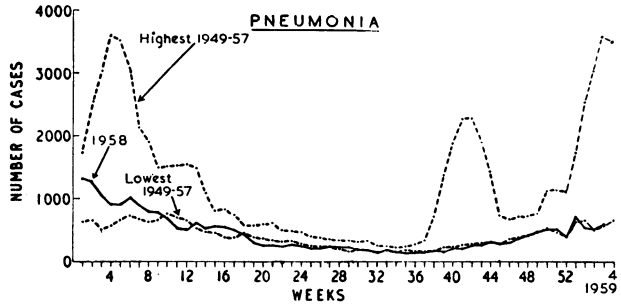
The number of workpeople (other than seamen) in the United Kingdom whose deaths from accidents in the course of their employment were reported in December, 1958, was 101, compared with 118 in the previous month and 119 in December, 1957.

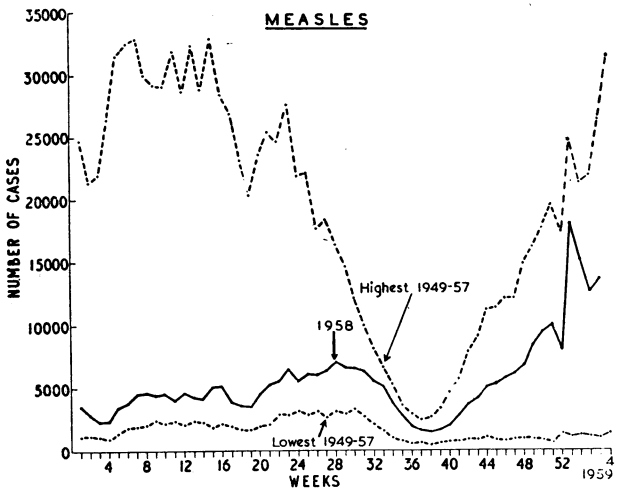
The numbers of cases of industrial diseases in the United Kingdom reported during December, 1958, were as follows: Lead poisoning 12, mercurial poisoning 3, compressed air illness 1, anthrax 1, epitheliomatous ulceration 30, chrome ulceration 20; total 67. There were eight deaths from epitheliomatous ulceration, 3 due to pitch and tar and 5 due to mineral oil.—*Ministry of Labour Gazette,* January, 1959.

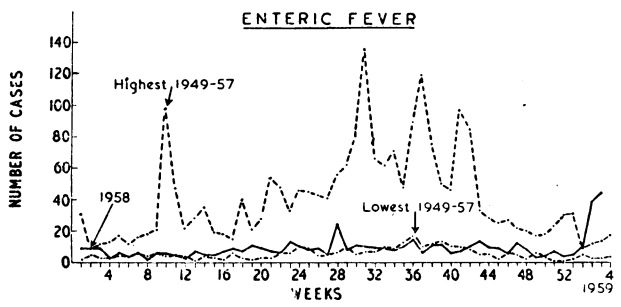
Graphs of Infectious Diseases

The graphs below show the uncorrected numbers of cases of certain diseases notified weekly in England and Wales. Highest and lowest figures reported in each week during the years 1949–57 are shown thus - - - - - -, the figures for 1958–9 thus ————. Except for the curves showing notifications in 1958–9, the graphs were prepared at the Department of Medical Statistics and Epidemiology, London School of Hygiene and Tropical Medicine.









INFECTIOUS DISEASES AND VITAL STATISTICS

Summary for British Isles for week ending **January 17** (No. 2) and corresponding week 1958.

Figures of *cases* are for the countries shown and London administrative county. Figures of *deaths* and *births* are for the whole of England and Wales (London included), London administrative county, the 17 principal towns in Scotland, the 10 principal towns in Northern Ireland, and the 14 principal towns in Eire.

A blank space denotes disease not notifiable or no return available.

The table is based on information supplied by the Registrars-General of England and Wales, Scotland, N. Ireland, and Eire, the Ministry of Health and Local Government of N. Ireland, and the Department of Health of Eire.

CASES	1959 Eng. & Wales	1959 Lond.	1959 Scot.	1959 N. Ire.	1959 Eire	1958 Eng. & Wales	1958 Lond.	1958 Scot.	1958 N. Ire.	1958 Eire
Diphtheria ..	5	2	2	0	4	7	1	6	0	4
Dysentery	839	69	177	12	1	574	119	114	7	4
Encephalitis, acute	3	0		0		3	0		0	
Enteric fever:										
Typhoid ..	1	1	1	0		2	0	0	0	1
Paratyphoid ..	37	2	0	0		7	0	1 (B)	0	
Food-poisoning ..	107	14	12	0		139	14	26	0	
Infective enteritis or diarrhoea under 2 years				7	15				11	11
Measles*	12,671	1001	536	89	615	2,888	39	90	83	13
Meningococcal infection	24	0	13	1	2	34	3	15	0	
Ophthalmia neonatorum	17	5	4	0		22	1	12	0	
Pneumonia† ..	527	39	350	13	2	1,292	123	568	6	21
Poliomyelitis, acute:										
Paralytic ..	21	1	} 1	1		{ 28	1	} 2	0	6
Non-paralytic ..	5	0				{ 8	0			
Puerperal fever§ ..	172	24	11	0	1	235	64	22	1	
Scarlet fever ..	1,103	63	88	22	22	501	34	69	12	6
Tuberculosis:										
Respiratory ..	481	61	75	20		566	68	82	30	
Non-respiratory	48	6	5	2		50	6	8	8	
Whooping-cough .	508	18	48	52	101	460	17	38	4	6

DEATHS	1959 Eng. & Wales	1959 Lond.	1959 Scot.	1959 N. Ire.	1959 Eire	1958 Eng. & Wales	1958 Lond.	1958 Scot.	1958 N. Ire.	1958 Eire
Diphtheria ..	0	0	0	0	1	No comparable figures available.	0	0	0	0
Dysentery	2	0		0			0		0	
Encephalitis, acute		0			0		0			
Enteric fever ..	0	0	0	0			0	0	0	
Infective enteritis or diarrhoea under 2 years	6	0	0	0	2		0	0	0	1
Influenza	33	1	4	1	1		21	2	0	4
Measles		0	1	0	0		0	0	0	0
Meningococcal infection		0	0				1	0		
Pneumonia ..	800	77	41	19	12		117	61	12	11
Poliomyelitis, acute	4	0		0	0		1		0	0
Scarlet fever ..		0	0	0	0		0	0	0	0
Tuberculosis:										
Respiratory ..	} 113	{ 11	14	3	5		10	9	1	3
Non-respiratory		{ 1	0	0	1		2	1	0	0
Whooping-cough ..	1	0	0	1	0		0	0	0	0
Deaths 0–1 year ..	352	34	42	4	23		43	58	8	11
Deaths (excluding stillbirths) ..	13,259	1098	872	164	215		1254	839	134	202
LIVE BIRTHS ..	14,554	1241	1048	254	362		1313	1142	238	353
STILLBIRTHS .	324	25	29				26	28		

* Measles not notifiable in Scotland, whence returns are approximate.
† Includes primary and influenzal pneumonia.
§ Includes puerperal pyrexia.